blue california
Promise Health Plan

Policy Title: Expedited QIO Review of Coverage Determinations		POLICY #: 50.2.21 Line of business: Medicare Adv	
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Department Head: Sr. Director, UM		**Date: 3/21**	
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PURPOSE

The purpose of this policy is to ensure and educate enrollees about the right to an expedited review by a Quality Improvement Organization ("QIO") and other appeal rights when an enrollee disagrees with Blue Shield of California Promise Health Plan's (Blue Shield Promise) decision to terminate coverage of services from a skilled nursing facility (SNF), home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF).

POLICY

Blue Shield Promise Health Plan will ensure that enrollees receive proper notification as required by the Center of Medicare and Medicaid Services (CMS) or their right to an expedited review by a QIO. Blue Shield Promise Health Plan will ensure that enrollees receive the Notice of Medicare Non-Coverage from the Providers. Blue Shield Promise Health Plan will have procedures for the delivery of the Detailed Explanation of Non-Coverage upon request for an expedited QIO review by the enrollee.

DEFINITIONS:

CMS: Center for Medicare and Medicaid Services

Independent Review Entity: An Independent entity contracted by CMS to review Blue Shield of California Promise Health Plan's adverse reconsiderations of organization determinations.

Organization Determination: Any determination made by Blue Shield Promise Health Plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a provider other than services the enrollee believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for or reimbursed by Blue Shield Promise Health Plan
- Discontinuation of a service if an enrollee believes that continuation of the services is medically necessary, or
- Failure of Blue Shield Promise Health Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide an enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Quality Improvement Organization (QIO): Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient department, hospital emergency rooms, SNFs, HHAs, the Plan, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

Reconsideration: An enrollee's first step in the appeal process after an adverse organization determination; the Plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative: An individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal (i.e., a QIO review). Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination or in dealing with any of the levels of the appeals process, subject to the applicable rules described in the CMS regulations and requirements.

OPERATING PROTOCOL:
Blue Shield Promise Health Plan shall ensure that enrollees receive the appropriate notices within the stated time frames which explain the enrollee's rights to an expedited QIO review or expedited reconsideration by Blue Shield Promise Health Plan, if necessary. CMS approved forms will be used for notification to enrollees.

Notice of Medicare Non-Coverage (NOMNC)
All enrollees receiving covered provider services will receive a Notice of Medicare Non-Coverage (NOMNC) from the provider at least two (2) calendar days in advance of the services ending, even if the enrollee agrees that the services should end.

If the enrollee does not agree that covered services should end, the enrollee may appeal by requesting an expedited review of the case by the QIO in the state where the services are being provided. Blue Shield Promise Health Plan will furnish a Detailed Explanation of Non-Coverage (DENC) explaining why services are no longer necessary or covered. The QIO review process will generally be completed within forty-eight (48) hours of the enrollee's request for a review.

- Blue Shield Promise Health Plan is generally responsible for determining the discharge date (in coordination with the physician in charge of the enrollee's care. Blue Shield Promise Health Plan must coordinate with SNFs, HHAs, or CORFs by providing the termination date as early in the day as possible to allow for timely delivery of the NOMNC. Blue Shield Promise Health Plan may choose to delegate these responsibilities to their contracted Providers, or make arrangements with non-contracted providers if Blue Shield Promise Health Plan is responsible for the enrollee utilizing the non-contracted provider, understanding that Blue Shield Promise Health Plan is ultimately responsible/liable for the provider's decisions;
- The provider is responsible for delivering the NOMNC on behalf of Blue Shield Promise Health Plan to enrollees no later than two (2) days before the enrollee's covered services end
- The enrollee (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if he or she wish to obtain an expedited review; and

- The QIO is responsible for immediately contacting Blue Shield Promise Health Plan and the provider if the enrollee requests an expedited review and making a decision on the case by no later than the close of business the day after the QIO receives the information necessary to make the decision.

Issuing the NOMNC
Providers must distribute the NOMNC at least two (2) calendar days prior to the enrollee's services ending. If the services are expected to be fewer than two (2) days in duration, the provider must provide the NOMNC to the enrollee at the time of admission. If, in a non-residential setting, the span of time between services exceeds two (2) days, the provider may deliver the NOMNC at the next to last time that services are furnished to prevent a non-residential provider from having to make an additional trip to deliver the NOMNC to the enrollee.

Valid Delivery
Valid delivery generally means that the enrollee must be able to sign the NOMNC to acknowledge receipt of the form. The enrollee must be able to understand that he or she may appeal the termination decision.

Valid delivery does not preclude the use of devices, witnesses, or interpreters for notice delivery. Therefore, if the enrollee is able to comprehend the notice, but either is physically unable to sign it, or needs the assistance of an interpreter to translate it or a device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. If the enrollee refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the enrollee refused to sign.

Except in rare circumstances, CMS believes valid delivery is best accomplished by face-to-face contact with the enrollee. However, if the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by the enrollee's representative. If a representative is not available to receive and sign the notice in person, the procedures as outlined in the Managed Care Manual Chapter 13 Section 60.1.3 are applicable. Occasionally, circumstances may prevent physical delivery of the NOMNC to an enrollee or the representative by the provider of Blue Shield Promise Health Plan, creating the need to use an alternate delivery method. In these cases, the provider of Blue Shield Promise Health Plan must document the reason for employing this alternative. QIOs will review the documentation provided to assess whether delivery was appropriate.

Detailed Explanation of Non-Coverage
The Detailed Explanation of Non-Coverage (DENC) is a standardized written notice that provides specific and detailed information to the Plan concerning why their covered services are ending. Blue Shield Promise Health Plan, or the delegated provider, must issue the DENC to the enrollee with a copy to the QIO whenever the enrollee appeals Blue Shield Promise Health Plan's termination decision regarding the enrollee's services.

The DENC will include:
- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;
- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee may obtain a copy of the Medicare policy from Blue Shield of California Promise Health;

- Any applicable Blue Shield Promise Health Plan policy, contract provision or rationale that the termination decision was based; and
- Facts specific to the enrollee and relevant to the coverage determination
- Information on the applicability of the coverage rule or policy in the enrollee's case.

Issuing DENC

Blue Shield Promise Health Plan shall issue the DENC to enrollees and provide a copy to the QIO no later than close of business (typically 4:30pm) of the day of the QIO's notification that the enrollee requested an appeal, or the day before coverage ends, whichever date is later.

The intent of the requirement that the enrollee receives the DENC is to make sure that enrollees who choose to contest a service termination or discharge are made aware of the reasoning for the coverage termination and have an opportunity to present their views to the QIO. Additionally, QIOs rely on the DENC to obtain the rationale for the termination decision, and any accompanying information regarding Blue Shield Promise Health Plan's coverage policies or Medicare rules that are relied on by Blue Shield Promise Health Plan in making its termination decision.

Fast-Track Review by the QIO of Provider Services Termination

An enrollee receiving services who wishes to obtain an independent appeal of the Blue Shield Promise Health Plan termination decision must submit a timely request for the fast-track review to the QIO. To be timely, an enrollee must request an appeal with the QIO either by noon of the day following receipt of the NOMNC, or by noon of the day before coverage ends (that is the "effective date" of the notice) if the enrollee receives the NOMNC more than two (2) days prior to the date coverage is expected to end.

An enrollee will not incur financial liability if the QIO reverses Blue Shield Promises Health Plan's decision or if the enrollee stops receiving care no later than the effective date listed on the NOMNC.

Blue Shield Promise Health Plan will be financially liable for continued services until two (2) days after the enrollee receives a valid NOMNC. An enrollee may waive continuation of services if he or she agrees with being discharged sooner than two (2) days after receiving the notice.

If an individual claiming to be an enrollee's representative requests an expedited QIO review but does not have the proper representative documentation, the QIO operating as an independent review entity under contract with CMS, must allow the filing as permitted under the HIPAA definition. However, Blue Shield Promise Health Plan and the QIO are only permitted to release protected health information to individuals in accordance with applicable HIPAA requirements.

Right to Request an Expedited Reconsideration

An enrollee who fails to request an immediate fast-track QIO review in accordance with the requirements above may request that Blue Shield of California Promise Health Plan perform an expedited reconsideration. Before accepting a request for an expedited reconsideration, Blue Shield Promise Health Plan must distinguish, by determining the appropriate time frame, between misdirected requests for reviews that should go to the QIO, and those expedited reconsideration requests that are being filed because the window for filing the request to the QIO has elapsed. Blue Shield Promise Health Plan shall establish the appropriate time frame for either accepting or forwarding requests for expedited reconsiderations by the following:

- If Blue Shield Promise Health Plan receives the request for an expedited reconsideration earlier than noon of the day following the date of the advance termination notice, Blue

Shield Promise Health Plan shall contact the QIO and inform the QIO that the enrollee wishes to file an immediate QIO review of a provider termination. Blue Shield Promise Health Plan must subsequently forward a detailed notice and the case file to the QIO. A copy of the detailed notice should also be sent to the enrollee, or

- If the QIO time frame for considering the appeal has elapsed, Blue Shield Promise Health Plan may consider the request as an expedited reconsideration to be processed. Blue Shield Promise Health Plan shall process these requests under the expedited reconsideration policies and procedures. If the reconsideration request is forwarded to the QIO, then Blue Shield Promise Health Plan shall educate the enrollee about his or her appeal rights to a QIO.

The enrollee has rights to all other levels of the Medicare appeals process.

REFERENCES